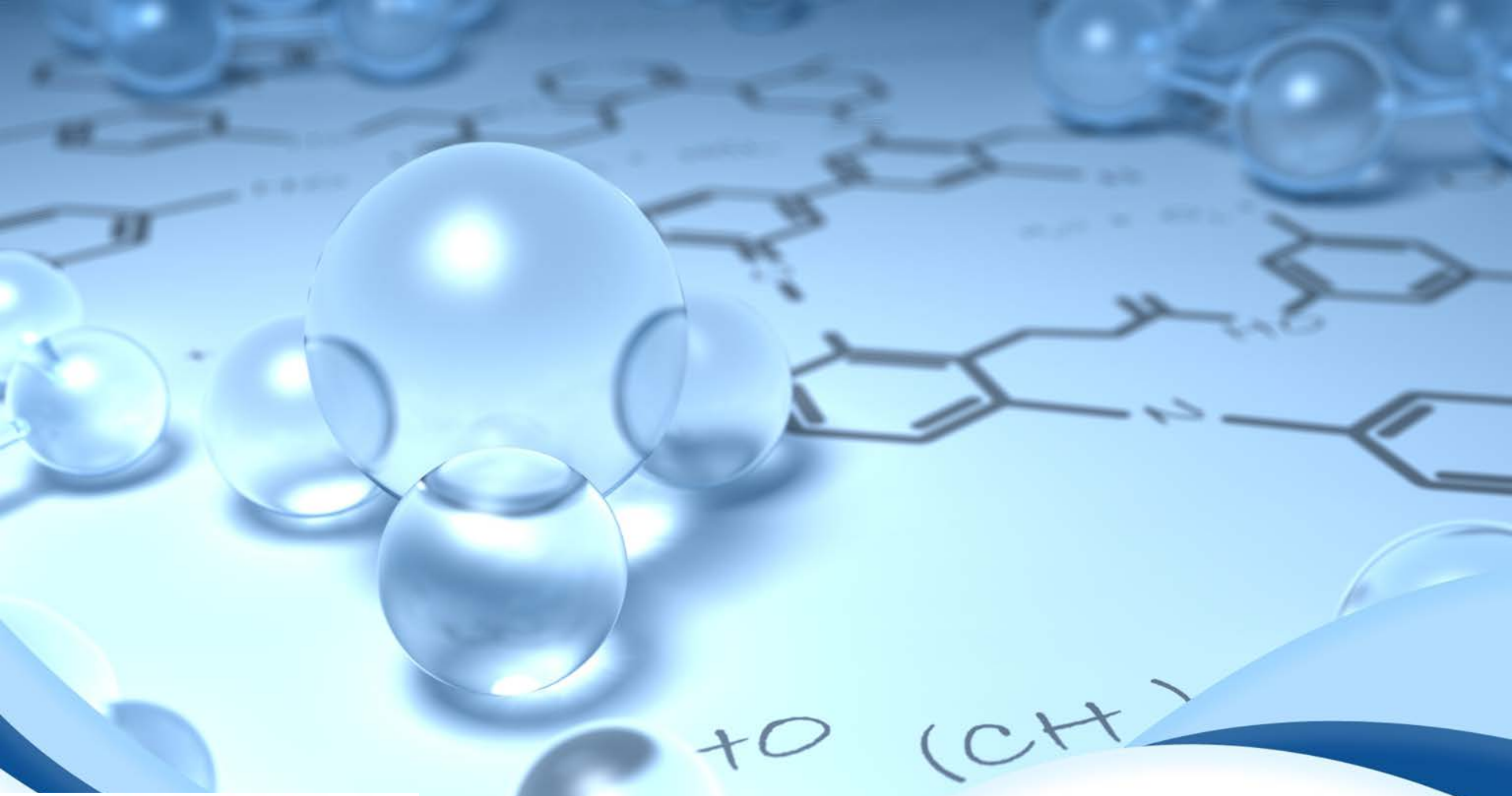
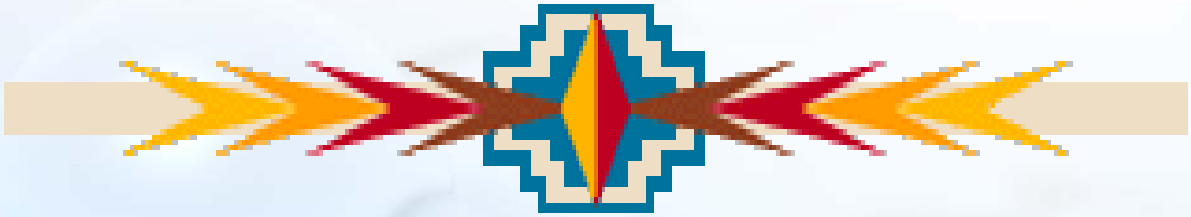


COMMUNITY ENGAGED RESEARCH

Dr. Donna Grandbois;

Fargo Moorhead Urban Indian Community

“A NATIVE AMERICAN COMMUNITY’S JOURNEY TO ACHIEVE CULTURALLY APPROPRIATE HEATH CARE”



KEY PREMISES

POINT 1	The Community has the Expertise
POINT 2	The Indigenous Worldview Matters!
POINT 3	Our Cultures Hold Our Medicine
POINT 4	Care Must Be Community-specific
POINT 5	The Community is Dynamic
POINT 6	Cultural Humility & Respect is Intrinsic

THE PROBLEM

Healthcare services do not exist for urban Indians w/o insurance in North Dakota:

- Indian Health Services are not within easy driving distances
- Many Urban Indians do not have tribal IDs
- There are no FQHC for Urban Indians in ND or Title V funding for services
- Fargo FQHC has not welcomed Native clients
- Lack of data contributed to the problem
- Low health literacy

Demonstrated Need for Community-Specific Data:

North Dakota was ranked "#1" by both Gallop & Healthway's for the highest "well-being scores" across the US.

Rankings were based on 6 Measures:

a) Access to basic needs
b) Healthy behavior
c) Work environment
d) Physical health
e) Emotional health
f) Life evaluation & optimism

(Dakota Nurse, v 12, 2, Spring 2014; p. 15)

The Stark Reality for North Dakota's Indian People: Cradle to grave inequities

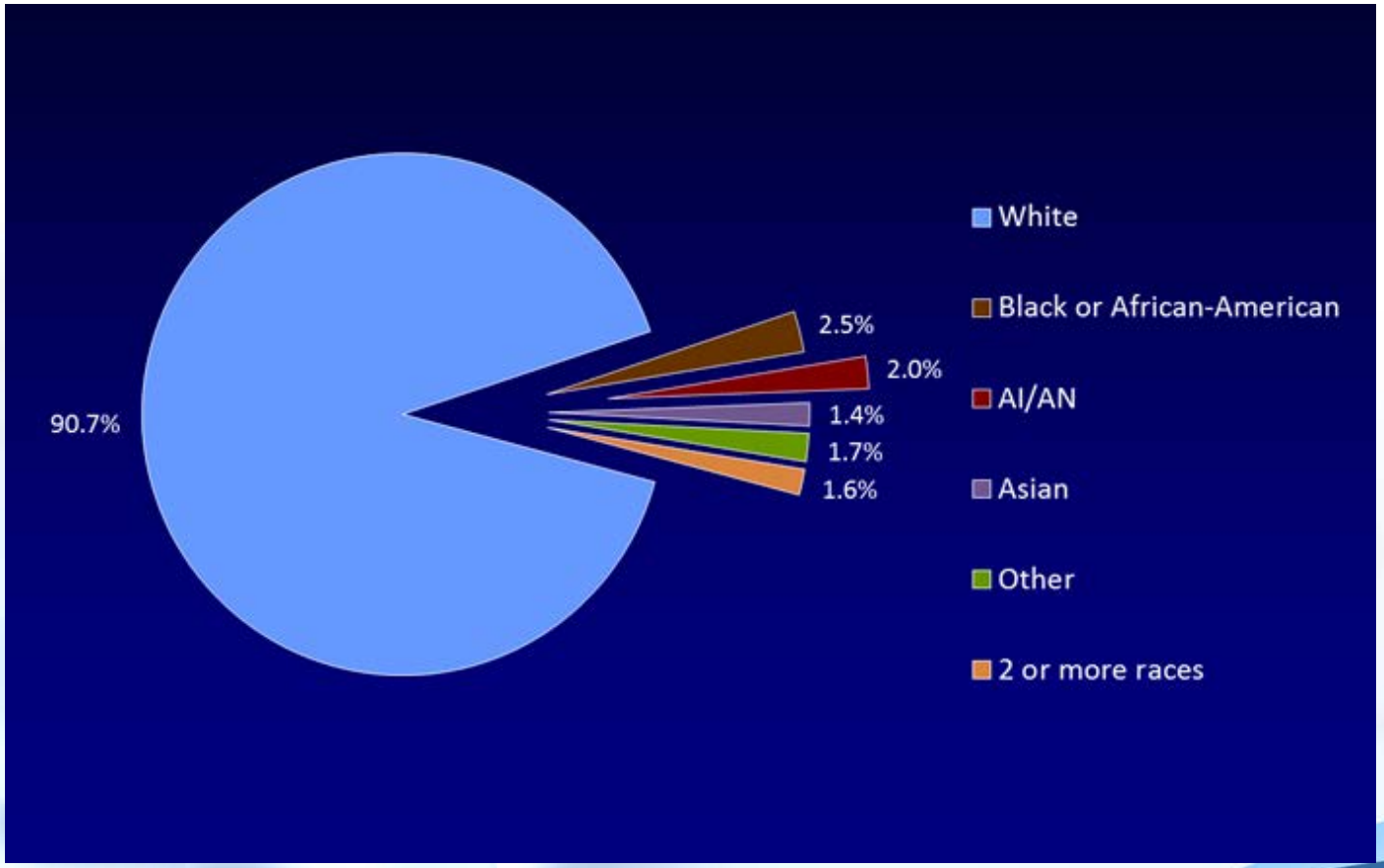
NATIVE AMERICANS

- Approximately 42,000
- Median household income: $25,255 (49.7% below 200% FPL)
- Unemployment: 14%
- High rates of disability at every age
- The lowest High School Graduation rate in the country
- Infant mortality rate 13.5
- Life Expectancy 54.7 years

NON-NATIVE POPULATION

- Approximately 672,000
- Median household income: $48,670
- Unemployment: 3%
- Low disability rates
- Among the highest High School Graduation rates in the country
- Infant mortality rate 7.5 (US)
- Life Expectancy 75.7 years

Race in the Northern Plains



Source: US Census Bureau, 2006-2008, American Community Survey

ND, SD, Iowa, & Nebraska

BACKGROUND

- Urban Indian Health & Wellness Center Established with 6 Native Board Members
- Held community forums & dialogues
- Greater Fargo Moorhead Community Health Needs Assessment Collaborative (CHNAS) (20 members; in response to 2010 healthcare reform mandate)
- Only 2 Natives completed the CHNAS survey
- Native American City commission funded the Native American survey; using the same tool
- 7-8 Native community members IRB certified to collect data (101 surveys/88 Native)

COMMUNITY STRENGTHS

F/M AI Health & Wellness Center

Public Health, Cultural, and Social Services

Greater F/M Community Health Needs Assessment Collaborative

C. Fuglesten-SE Human Services

C. McLeod- Sanford Health

D. Watne- Dakota Medical Foundation

D. Grandbois- American Indian Pop.

G. Nolte-Clay County Public Health

K. Olson-State Data Center

K. Dulski- Essentia Health

K. Schwarzwalter-NDSU

K. Lipetzky- Fargo Cass Public Health

M.Miller- Center for Rural Health

M. Henderson- Family Healthcare Center (FQHC)

P. Patrone: Family Heathcare Center

R. Danielson-NDSU

R. Rathge- NDSU

R. Bachmeier- Cass County Public Health

S. Thomsen-United Way Cass/Clay

S. Borgen- Essentia Health

T. Hill- United WAy

What is CBPR?

"… a ***truly collaborative approach to research*** that ***equitably involves all partners*** in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the ***aim of combining knowledge with action*** and achieving social change ***to improve health outcomes and eliminate health disparities***."

Source: Kellogg Health Scholars Program. [cited 2012 November 13]. Retrieved from: http://www.kellogghealthscholars.org/about/community.cfm

Community-engaged Research Principles

- Recognizes community as a unit of identity
- Builds on strengths and resources
- Facilitates partnership in all phases of research
- Promotes shared learning to solve social inequalities
- Addresses health from positive and ecological perspectives
- Disseminates findings and knowledge to all partners
- Involves long-term commitment by all partners

Source: Adapted from : Israel, BA, Schulz, AJ, Parker, EA, Becker, AB, Allen, AJ, and Guzman, JR. "Critical Issues in developing and following CBPR principles," Community-Based Participatory Research in Health, Minkler and Wallerstein (eds), Jossey Bass, 2000.

METHODS

A mixed-method community-based participatory research (CBPR) collaboration with the F/M Urban Indian community was implemented.

Phase I: Urban Indian volunteers were IRB certified by NDSU

Native American City Commission funded the survey

Survey was conducted by community members

Both paper & computer access to the survey were provided.

Group Decision Center, NDSU, was used to collect the surveys and provide a report on the results

PHASE I

Began with Relationship Building & Community Service.

Relationships were built with:

- **Community Coalition**
- **Grass-roots community organizations**
- **Native & Non-Native Leadership**
- **Community Dialogues & Forums were held**
- **Key Native Elders**

Phase One included the community-wide survey & the community-specific survey

PHASE II: Building on Phase I

- Adapt the survey tool to be Native specific
- Define culturally appropriate care for “this” community
- The voices of the Elders must be sought out & included in focus groups
- American Indian Community Leaders must be asked to participate
- Semi-structured focus groups and individual interviews will be conducted to further define, clarify, and provide future direction

OUTCOMES; SO FAR!

- Capacity to generate their own data as needed
- Awareness of biopsychosocial and economic status
- Determine & set priorities to address specific needs
- Support community focused grant applications
- Community buy-in with the larger community: Be recognized as a viable partner in key community health and socioeconomic strategic plans
- Monitor their own progress toward becoming a healthy community

Outcomes; Possibilities, & Dreams

- Native community leaders can support and make a case to local, state, and federal policy-makers and legislators, using the data, to meet community needs
- With ACA, more urban Indians will have insurance;
- Therefore, access issues toward culturally compatible healthcare services may need to be re-envisioned.

Finally: Community Empowerment

The data and the development of community cohesiveness, partnerships, and collaborations are vital as this urban Indian community works to build a healthy, welcoming community.

A Ways To Go!

SOCIAL JUSTICE

"Enables people to claim their human rights, meet their needs, and have greater control over the decision-making processes that affects their lives"

HUMAN RIGHTS COMMISSION

North Dakota Human Rights Coalition (NDHRC) was formed as recently as 2002. There is Native representation!

THANK YOU FOR YOUR TIME & ATTENTION!
ANY QUESTIONS?